



## CONEJO VALLEY UNIFIED SCHOOL DISTRICT OUTDOOR SCHOOL HEALTH FORM

Student's Name, Last Name First (please print clearly) \_\_\_\_\_

School \_\_\_\_\_

The following remedies will be available to use if needed by your child during their stay at Outdoor School:

- |   |  |
|---|--|
| 1. Children's Tylenol for headaches                     | 4. Calamine lotion for itching             |
| 2. Tums for upset stomach                               | 5. Neosporin ointment for cuts / abrasions |
| 3. Cough Drops and mouthwash for coughs or sore throats | 6. Benadryl                                |

**I agree that the above remedies may be used, as needed, by my child.**

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Personal Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

*\*This form is in addition to the Field Trip or Excursion Authorization and Medical Treatment Authorization form for minors (SFA-2010 and SFA 2010S) and is not intended to replace the Authorization form.*

To help us better meet your child's needs, please complete the following information:

1. Is your child allergic to any medication or foods? \_\_\_\_\_  
If so, please list in detail and to what degree these foods should be avoided: \_\_\_\_\_  
\_\_\_\_\_
2. Does your child have any special dietary requirements? Please **circle** all that apply:  
Kosher    vegetarian    gluten-free    no pork    no beef    lactose intolerant
3. Does your child require an Epi- pen for any of the noted allergies above? \_\_\_\_\_  
\_\_\_\_\_
4. Does your child walk in their sleep, need to limit liquids, or have any other problems sleeping? \_\_\_\_\_  
If so, please specify \_\_\_\_\_
5. Are there any other factors which might affect the care of your child, such as asthma, allergies, diabetes, seizures, etc.? If so, please describe \_\_\_\_\_  
\_\_\_\_\_
6. Has your child been exposed to any communicable diseases within the past 21 days? If so, which one(s) \_\_\_\_\_
7. Has your child had a tetanus shot? \_\_\_\_\_ If so, when? \_\_\_\_\_
8. Do you know of any health factor that makes it advisable for your child to follow a limited program of physical activity (sprains, broken limb, etc.)? \_\_\_\_\_ If yes, explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_